HOUSE BILL No. 1644

DIGEST OF INTRODUCED BILL

Citations Affected: IC 5-10-8.1-9; IC 27-8-5.7-10; IC 27-13-36.2-8; IC 35-43-5.

Synopsis: Insurance fraud. Allows a state employee health benefit plan administrator, an insurer, or a health maintenance organization to investigate a claim believed to be falsely submitted. Allows a court to order a provider convicted of fraud with respect to a claim to make restitution and pay certain costs related to the claim.

Effective: July 1, 2005.

Ripley

January 19, 2005, read first time and referred to Committee on Insurance.

Introduced

First Regular Session 114th General Assembly (2005)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type.~~

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 2004 Regular Session of the General Assembly.

HOUSE BILL No. 1644

A BILL FOR AN ACT to amend the Indiana Code concerning insurance.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 5-10-8.1-9 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: **Sec. 9. (a) If an administrator has a reasonable basis on which to believe that a claim submitted for payment:**

(1) is false;

(2) falsely represents that the services that are the subject of the claim were medically necessary in accordance with professionally accepted standards; or

(3) contains false statements or false representation of a material fact;

the administrator is exempt from the requirements of sections 6 and 7 of this chapter for thirty (30) days to allow the administrator to investigate the claim.

(b) If, upon completion of an investigation under subsection (a), the administrator determines that the claim is valid, the administrator shall process the claim according to the requirements of sections 6 and 7 of this chapter.

(c) Upon a finding by a:

(1) court with jurisdiction; or

(2) state or federal agency in a disciplinary or an administrative action;

that a provider has submitted a false or misleading claim to an administrator, sections 6 and 7 of this chapter do not apply to any subsequent claim submitted to the administrator by the provider.

(d) If a state agency takes action against a provider in connection with a provider's submission of false or misleading claims, the agency shall notify the department of insurance of the action. The department of insurance shall make available on the department's Internet web site the name of the provider and the action taken against the provider by the department of insurance or other state agency in connection with the provider's submission of false and misleading claims.

(e) If a provider appeals a finding specified in subsection (c) and the finding is overturned, reversed, or vacated, subsection (d) does not apply.

SECTION 2. IC 27-8-5.7-10 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: **Sec. 10. (a) If an insurer has a reasonable basis on which to believe that a claim submitted for payment:**

(1) is false;

(2) falsely represents that the services that are the subject of the claim were medically necessary in accordance with professionally accepted standards; or

(3) contains false statements or false representation of a material fact;

the insurer is exempt from the requirements of sections 5 and 6 of this chapter for thirty (30) days to allow the insurer to investigate the claim.

(b) If, upon completion of an investigation under subsection (a), the insurer determines that the claim is valid, the insurer shall process the claim according to the requirements of sections 5 and 6 of this chapter.

(c) Upon a finding by a:

(1) court with jurisdiction; or

(2) state or federal agency in a disciplinary or an administrative action;

that a provider has submitted a false or misleading claim to an insurer, sections 5 and 6 of this chapter do not apply to any subsequent claim submitted to the insurer by the provider.

(d) If a state agency takes action against a provider in connection with a provider's submission of false or misleading claims, the agency shall notify the department of the action. The department shall make available on the department's Internet web site the name of the provider and the action taken against the provider by the department or other state agency in connection with the provider's submission of false and misleading claims.

(e) If a provider appeals a finding specified in subsection (c) and the finding is overturned, reversed, or vacated, subsection (d) does not apply.

SECTION 3. IC 27-13-36.2-8 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: **Sec. 8. (a) If a health maintenance organization has a reasonable basis on which to believe that a claim submitted for payment:**

(1) is false;

(2) falsely represents that the services that are the subject of the claim were medically necessary in accordance with professionally accepted standards; or

(3) contains false statements or false representation of a material fact;

the health maintenance organization is exempt from the requirements of sections 3 and 4 of this chapter for thirty (30) days to allow the health maintenance organization to investigate the claim.

(b) If, upon completion of an investigation under subsection (a), the health maintenance organization determines that the claim is valid, the health maintenance organization shall process the claim according to the requirements of sections 3 and 4 of this chapter.

(c) Upon a finding by a:

(1) court with jurisdiction; or

(2) state or federal agency in a disciplinary or administrative action;

that a provider has submitted a false or misleading claim to a health maintenance organization, sections 3 and 4 of this chapter do not apply to any subsequent claim submitted to the health maintenance organization by the provider.

(d) If a state agency takes action against a provider in connection with a provider's submission of false or misleading claims, the agency shall notify the department of the action. The department shall make available on the department's Internet web site the name of the provider and the action taken against the

provider by the department or other state agency in connection with the provider's submission of false and misleading claims.

(e) If a provider appeals a finding specified in subsection (c) and the finding is overturned, reversed, or vacated, subsection (d) does not apply.

SECTION 4. IC 35-43-5-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: Sec. 1. (a) The definitions set forth in this section apply throughout this chapter.

(b) "Claim statement" means **a health benefit plan (as defined in IC 5-10-8.1-4),** an insurance policy, **a health maintenance organization contract,** a document, or a statement made in support of or in opposition to a claim for payment or other benefit under **a health benefit plan,** an insurance policy, **or a health maintenance organization contract,** or other evidence of expense, injury, or loss. The term includes statements made orally, in writing, or as a computer generated document, including the following:

(1) An account.
(2) A bill for services.
(3) A bill of lading.
(4) A claim.
(5) A diagnosis.
(6) An estimate of property damages.
(7) A hospital record.
(8) An invoice.
(9) A notice.
(10) A proof of loss.
(11) A receipt for payment.
(12) A physician's records.
(13) A prescription.
(14) A statement.
(15) A test result.
(16) X-rays.

(c) "Coin machine" means a coin box, vending machine, or other mechanical or electronic device or receptacle designed:

(1) to receive a coin, bill, or token made for that purpose; and
(2) in return for the insertion or deposit of a coin, bill, or token automatically:
(A) to offer, provide, or assist in providing; or
(B) to permit the acquisition of;
some property.

(d) "Credit card" means an instrument or device (whether known as a credit card or charge plate, or by any other name) issued by an issuer

for use by or on behalf of the credit card holder in obtaining property.

(e) "Credit card holder" means the person to whom or for whose benefit the credit card is issued by an issuer.

(f) "Customer" means a person who receives or has contracted for a utility service.

(g) "Entrusted" means held in a fiduciary capacity or placed in charge of a person engaged in the business of transporting, storing, lending on, or otherwise holding property of others.

(h) "Identifying information" means information that identifies an individual, including an individual's:

(1) name, address, date of birth, place of employment, employer identification number, mother's maiden name, Social Security number, or any identification number issued by a governmental entity;

(2) unique biometric data, including the individual's fingerprint, voice print, or retina or iris image;

(3) unique electronic identification number, address, or routing code;

(4) telecommunication identifying information; or

(5) telecommunication access device, including a card, a plate, a code, a telephone number, an account number, a personal identification number, an electronic serial number, a mobile identification number, or another telecommunications service or device or means of account access that may be used to:

(A) obtain money, goods, services, or any other thing of value; or

(B) initiate a transfer of funds.

(i) "Insurance policy" includes the following:

(1) An insurance policy.

(2) A contract with a health maintenance organization (as defined in IC 27-13-1-19).

(3) A written agreement entered into under IC 27-1-25.

(j) "Insurer" has the meaning set forth in IC 27-1-2-3(x).

(k) "Manufacturer" means a person who manufactures a recording. The term does not include a person who manufactures a medium upon which sounds or visual images can be recorded or stored.

(l) "Make" means to draw, prepare, complete, counterfeit, copy or otherwise reproduce, or alter any written instrument in whole or in part.

(m) "Metering device" means a mechanism or system used by a utility to measure or record the quantity of services received by a customer.

(n) "Public relief or assistance" means any payment made, service

rendered, hospitalization provided, or other benefit extended to a person by a governmental entity from public funds and includes poor relief, food stamps, direct relief, unemployment compensation, and any other form of support or aid.

(o) "Recording" means a tangible medium upon which sounds or visual images are recorded or stored. The term includes the following:

(1) An original:

(A) phonograph record;

(B) compact disc;

(C) wire;

(D) tape;

(E) audio cassette;

(F) video cassette; or

(G) film.

(2) Any other medium on which sounds or visual images are or can be recorded or otherwise stored.

(3) A copy or reproduction of an item in subdivision (1) or (2) that duplicates an original recording in whole or in part.

(p) "Slug" means an article or object that is capable of being deposited in a coin machine as an improper substitute for a genuine coin, bill, or token.

(q) "Utility" means a person who owns or operates, for public use, any plant, equipment, property, franchise, or license for the production, storage, transmission, sale, or delivery of electricity, water, steam, telecommunications, information, or gas.

(r) "Written instrument" means a paper, a document, or other instrument containing written matter and includes money, coins, tokens, stamps, seals, credit cards, badges, trademarks, medals, retail sales receipts, labels or markings (including a universal product code (UPC) or another product identification code), or other objects or symbols of value, right, privilege, or identification.

SECTION 5. IC 35-43-5-4 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: Sec. 4. **(a)** A person who:

(1) with intent to defraud, obtains property by:

(A) using a credit card, knowing that the credit card was unlawfully obtained or retained;

(B) using a credit card, knowing that the credit card is forged, revoked, or expired;

(C) using, without consent, a credit card that was issued to another person;

(D) representing, without the consent of the credit card holder, that the person is the authorized holder of the credit card; or

(E) representing that the person is the authorized holder of a credit card when the card has not in fact been issued;

(2) being authorized by an issuer to furnish property upon presentation of a credit card, fails to furnish the property and, with intent to defraud the issuer or the credit card holder, represents in writing to the issuer that the person has furnished the property;

(3) being authorized by an issuer to furnish property upon presentation of a credit card, furnishes, with intent to defraud the issuer or the credit card holder, property upon presentation of a credit card, knowing that the credit card was unlawfully obtained or retained or that the credit card is forged, revoked, or expired;

(4) not being the issuer, knowingly or intentionally sells a credit card;

(5) not being the issuer, receives a credit card, knowing that the credit card was unlawfully obtained or retained or that the credit card is forged, revoked, or expired;

(6) with intent to defraud, receives a credit card as security for debt;

(7) receives property, knowing that the property was obtained in violation of subdivision (1) of this section;

(8) with intent to defraud the person's creditor or purchaser, conceals, encumbers, or transfers property;

(9) with intent to defraud, damages property;

(10) knowingly and with intent to defraud, makes, utters, presents, or causes to be presented to **an administrator under IC 5-10-8.1,** an insurer, **a health maintenance organization,** or ~~an insurance~~ **a** claimant **under a health benefit plan, an insurance policy, or a health maintenance organization contract,** a claim statement that contains false, incomplete, or misleading information concerning the claim; or

(11) knowingly or intentionally:

(A) sells;

(B) rents;

(C) transports; or

(D) possesses;

a recording for commercial gain or personal financial gain that does not conspicuously display the true name and address of the manufacturer of the recording;

commits fraud, a Class D felony.

(b) The court may order a person who violates subsection (a)(10) to pay restitution, including court costs and attorney's fees, to the administrator, insurer, or health maintenance organization

that paid the claim that is the subject of the violation.